- General Considerations
- History Taking
- Review of Body Systems
- Physical Examination
- Symptoms and Signs
- Making Conclusions
- Diagnosing the Unconscious Patient
- Emergency Medical Identification Symbol

Chapter II

Examination of the Patient

GENERAL CONSIDERATIONS

A SYSTEMATIC AND COMPLETE EXAMINATION of the patient is essential to evaluate the extent of a person's illness. An examination is composed of two basic parts: (1) the *history,* a chronological story of the patient's illness from the first symptoms to the present time; and (2) the *physical examination,* in which the patient is examined for physical evidence of disease. The findings should be recorded accurately, concisely, and completely.

Many patients reporting to sickbay may have a minor illness or injury, as a splinter or blister which often requires only a brief examination prior to treatment for the specific complaint. Patients who appear quite ill will require a thorough evaluation and a more detailed examination.

An accurate record should be made of all phases of every illness, beginning with the history and physical examination. Daily records should be kept during the course of the illness. Many times, the diagnosis will not be evident when the patient is first seen; but, as complaints and delayed physical signs appear in the next several days, the symptom complex may become clearer. Originally, many infectious diseases present themselves with only fever and general malaise, but in several days a rash may appear (as in measles); or jaundice (as in hepatitis); or a stiff neck and coma (as in meningitis). These signs and symptoms help to establish a definitive diagnosis. Many times the patient's complaints will change after a period of time ranging from several hours to days; or more information will be offered. Many patients unconsciously omit important facts due to fear created by their illness. This added information may modify or change the diagnosis.

A clear, concise recording of signs and symptoms of the patient's illness is important in communication by radio, or when a patient is transferred to a physician's care. At times, the patient may be unable to speak coherently or remember exactly what has happened during the illness. If accurate and complete records have been made, they may prove lifesaving in establishing a correct diagnosis promptly.

HISTORY TAKING

Taking the history is an important part of the examination and often a diagnosis may be made from the history alone. Techniques that help to obtain a meaningful history should be studied, practiced, and reviewed. A patient may tell his history in various ways. All possible information should be obtained and organized logically to tell the story of the patient's illness. Arranging symptoms into a diagnostic pattern may seem difficult at first; however, this will become easier with experience.

Recording the History

The recorded history should begin with the time the patient first noted any symptoms of sickness, body changes, or a departure from good health. Symptoms and events up to the present time should be included. The dates or times that various symptoms appeared should be noted as precisely as possible. The patient should be encouraged to talk freely without interruption. Specific leading questions should be asked. Many patients cannot give a good history and it will be necessary to prod their memories with leading questions, or encourage them to be more detailed in describing the illness.

Some questions that will help the patient to give the history are:

"How did your illness start?"
"What was the first symptom you noticed?"
"How long have you had this?"
"How and where does it affect you?"
"What followed?"

Later, more detailed questions may be asked that will help to diagnose the illness. To help decide on other questions to ask, reference may be made to sections of this book, or other medical books available aboard ship. *It's important to be specific about the main symptom or symptoms,* such as pain in the abdomen (See Table 2–1) or severe headache. Time should not be wasted with vague symptoms such as tiredness, weakness, and loss of appetite. These non-specific symptoms are a part of almost every illness. The patient should be asked if ever he had experienced similar symptoms or had the condition or problem before. He should be asked for the diagnosis of any similar situation in the past, the treatment that was prescribed, and the medications he had taken. Also, any medications that the patient is taking now should be noted, because his present illness might be an aggravation or complication of a chronic illness or a reaction to the medication.

Pain

Pain is one of the most common bodily symptoms. These are questions that should be asked:

"How did the pain start?" "What were you doing at the time?"

"Where is the pain located?" (Ask the patient to point to the area of pain so you can be specific in your notes.)

"How severe is the pain?" "Does it make you double up?" "What is the pain like?" (Such as cramping, sharp, dull, or aching.) "Is it constant or intermittent?"

"Does the pain radiate to any other body area?"

"Has it ever moved from one area to another?"

"Is there a way you can bring on the pain or relieve it?"

"Is there anything that makes the pain worse?"

"Do medications help?"

Past Illnesses

Next, the patient should be asked to describe any past illnesses, injuries, or operations. This will help rule out certain conditions. For example, if he has had an appendectomy, then pain in the right lower quadrant of the abdomen can't be acute appendicitis. Or an illness may be a recurrence. If he had been hospitalized in the past for a duodenal ulcer and now comes in with burning mid–upper abdominal pain that is relieved by antacids and milk, then he probably is having pain from a recurrent ulcer. Previous diagnoses should be kept in mind, such as diabetes or high blood pressure; these conditions may get worse during an illness and cause complications. The patient should be asked if he is allergic to any drugs, or if any drugs have made him ill.

REVIEW OF BODY SYSTEMS

When the diagnosis is not obvious or complete and if time permits, a general review of the various body systems and associated symptoms may be helpful. It may help to see that different symptoms relate to one system. For example a patient may have chest pain, shortness of breath when lying in bed, swelling of his legs, and a history of high blood pressure. These symptoms can be found in a cardiac patient so the possibility of heart disease should be considered. However, too much importance should not be placed on just one symptom. For example, shortness of breath can relate to other systems, as the respiratory system (as

Table 2–1. SEVERE ABDOMINAL PAIN

Position and Type of Pain	Associated Symptoms		Associated Signs				Probable Cause of the Pain
	Vomiting	Diarrhea	General Condition of Patient	Temperature	Pulse Rate	Abdominal Tenderness	
All over abdomen, or mainly about navel and lower half; sharp, coming and going in spasms	None	Usually not at first, but sometimes coming on later	Not ill; usually walks about, even if doubled up	Normal	Normal	None; on the contrary, pressure eases the pain	**Intestinal colic** (see p. V–14)
In upper part, and under left ribs, a steady burning pain	Present, and usually repeated	Not at first; it may follow 24–48 hours later	Wretched, because of nausea, vomiting and weakness, but soon improving	Usually normal; may be raised up to 100° F (37.8° C) in severe cases	Slightly raised, up to 80–90	Sometimes, but not severe and confined to upper part of abdomen	**Acute indigestion** (see p. V–29)
Shooting from loin to groin and testicle; very severe, agonizing spasms	May be present, but only with the spasms	None	Severe distress	Normal, or below normal	Rapid, as with shock	Over the loin	**Renal colic (kidney stones)** (see p. V–36)
Shooting from the upper part of the right side of abdomen to the back or right shoulder; agonizing spasms	May be present, but only with the spasms	None	Severe distress	Normal, or below normal	Rapid, as with shock	Just below the right ribs	**Gallstones (biliary colic)** (see p. V–28)
Around navel at first, settling later in the lower part of the right side of abdomen; usually continuous and sharp; not always severe	Soon after onset of pain, usually only once or twice	Sometimes once at commencement of attack; thereafter constipation exists	An ill patient—tends to lie still	Normal at first, but always rising later, up to 100° F (37.8° C); it may be raised more	Raised all the time (over 85), and tending to increase in rate hour by hour	Definitely present in the right side of the lower part of the abdomen	**Appendicitis** (see p. V–15)
All over the abdomen, usually severe and continuous	Present, becoming more and more frequent	Usually none	An extremely ill patient with wasted appearance, afraid to move because of pain	Present up to 103° F (39.4° C) or more, except in final stage near death	Rapid (over 110) and feeble	Very tender, usually all over; wall of abdomen tense	**Peritonitis** (see p. V–31)
Spasmodic at first, but later continuous	Increasing in frequency and amount of brown fluid	None; complete constipation exists	Very ill	Normal	Rising steadily, feeble	Slightly, all over. Wall of abdomen not hard but distended	**Intestinal obstruction** (see p. V–29)
In the groin, a continuous and severe pain	Not at first, but later as with obstruction	None; as with obstruction	Very ill	Normal	Rising steadily, feeble	Over the painful lump in the groin	**Strangulated hernia (rupture)** (see p. V–33)
Severe and continuous pain, worst in the upper part of the abdomen	Rare	None	Severe shock at first, then very ill; afraid to move because of the pain	Normal or below normal at first; rising about 24 hours later	Normal at first, rising steadily a few hours later	All over; worst over site of pain. Wall of abdomen hard	**Perforated ulcer of stomach** (see p. V–30)

Source: ***The Ship Captain's Medical Guide.*** *Department of Trade and Industry, Her Majesty's Stationery Office, London, England. Twentieth Edition. Reprinted 1973. p. 171.*

in pneumonia), or it can follow a bleeding episode.

The patient should be asked if he *now* has any of the following things to report:

Head—History of wounds (trauma), severe headaches.

Eyes—Blurred vision, double vision, pain, yellow color of the sclera (white part of eye), pain on looking at light.

Ears—Loss of hearing, severe dizziness, pain, or drainage.

Nose—Bleeding, runny, or stuffy.

Mouth—Sores, pain, trouble swallowing.

Neck—Stiffness, enlarged glands, tenderness.

Respiratory—Cough and character of material coughed up, coughing up blood, chest pain when breathing, shortness of breath.

Cardiac—Pain in middle of chest, swelling of both legs, shortness of breath on exercising or when sleeping flat in bed, forceful or rapid heart beat, history of high blood pressure, heart attack, history of rheumatic fever.

Gastrointestinal—Poor appetite, indigestion, nausea, vomiting, diarrhea, constipation, jaundice, pain in stomach, blood in stool or vomitus.

Genitourinary—Pain when urinating, pain in middle of back, frequent urination, straining to urinate, blood or pus in urine, discharge from penis.

Neurological—Paralysis or severe weakness of a part of the body (an arm or legs), convulsion, or seizure.

Family and Social History—The patient should be asked if diabetes, tuberculosis, heart disease, cancer, or other diseases ever appeared in other members of his family. These now may be appearing in the patient. Also ask about the amount of alcohol and tobacco the patient uses. The date of his last drink should be noted if chronic alcoholism is suspected, because delirium tremens may start five to seven days after a patient stops drinking.

Endocrine Disorders—Weight change, unusual hunger, unusual thirst, bulging eyes, intolerance to heat or cold.

PHYSICAL EXAMINATION

This is the second basic part in the evaluation of the patient. By this time, some observations of the patient will have been made, such as speech, general appearance, and mental status. Now, another system of collecting information must be used, wherein definitive signs of disease must be observed. Check the corresponding parts of the patient's body. For example, compare his right eye with the left eye, right arm with the left arm, and the right side of the chest with the left side.

To do a basic examination, a clock or watch with a second hand, blood pressure apparatus, stethoscope, thermometer, and a quiet room will be needed.

Vital Signs

- What is the blood pressure? Does it drop 15 mm or more when the patient stands for 3 minutes?
- What is the pulse rate per minute? Is it regular? Does it increase 15 beats or more per minute when the patient stands 3 minutes?
- What is the respiratory rate per minute?
- What is the patient's temperature?

General Appearance

- Note the position of the patient's body and his facial expression.
- Is he tense, restless, or in any unusual posture? Note his general ability to move and respond.

Skin

- Note location of rashes or sores.
- Is the rash red, made up of small or large spots? Are the spots separated, or do they run together? Do they itch? Are they elevated or flat?
- Is the skin hot and dry, or cold and wet?
- What is the color of the skin? Is there evidence of jaundice (yellowness)?
- Are his lips and nailbeds a dusky blue color, or are they pale and white?

Head

- Is there evidence of trauma, such as a cut, bruise, or swelling?

Eyes

• The patient should be asked if he can see. Each eye should be tested independently by having him identify certain objects or numbers.

• Is there evidence of jaundice or inflammation in the sclera (white part of the eye)? (Check for jaundice in the sunlight, if possible; in many normal people, there is a slight yellow cast of the sclerae in artificial light.)

• Can he move both eyes together up and down, and to each side? Is there an abnormal twitching to the eyes in any position?

• Are the pupils the same size? Do they get smaller when a light is shined into the eyes?

Ears

• Check for blood in the ear canal, especially if a blow to the head is known or suspected.

• Check his ability to hear by having him listen for ticking of a watch held at about the same distance from each ear. If the examiner's hearing is normal, he may compare his hearing with that of the patient.

Nose

• Look for bleeding or abnormal discharge.

Mouth and Throat

• Are the gums swollen or extremely red?

• Are the color and movement of the tongue unusual?

• Does the throat have abnormal redness, swelling or ulcerated patches?

• Observe the patient swallow. Does he have difficulty swallowing?

• Note any abnormal odor to the breath.

Neck

• The patient should be asked to lie down and the examiner's hands placed behind his head. When he is relaxed, the head should be lifted gently, bending the neck so that his chin will touch his chest. Observe for (1) an unnatural stiffness of the neck or (2) discomfort when the legs are lifted from the table with the knees straight.

• Check for any enlarged glands on the side of his neck. Note if they are tender, movable, soft, or hard.

Chest

• The patient's breathing should be observed. Note if it is painful, and if both sides of the chest move together.

• Note if he has to sit up to breathe.

• The hand should be placed flat on different parts of his chest to check for abnormal vibrations or tenderness.

• A stethoscope should be used to listen to all areas in the front and back, and compare each side. Normally, when a patient breathes, the air can be heard moving in and out, sounding like wind blowing through trees. Listen for wheezes, bubbling, or other sounds that are abnormal.

Abdomen

• Look at the contour. Is it symmetrical?

• Ask about any scars. They may indicate previous surgery and rule out certain diseases of the gallbladder or appendix, if these organs have been removed.

• Feel the abdomen noting tender areas or masses. Is the abdomen soft or rigid?

• If any organs such as the liver can be felt, note if they are tender, firm or soft. (Any time the examiner causes pain during an examination, he should ask the patient if this duplicates pain that has been described previously in the history.)

• Listen to the abdomen with the stethoscope. Low gurgling sounds should be heard about every 30 seconds. (They may be loud enough to hear without a stethoscope, as when one's stomach "growls." It is important to determine if this occurs almost constantly or not at all.)

Genitalia

• Check for sores, as in syphilis, being careful not to touch any sores.

• Is there any discharge from the penis?

• Check the testicles for swelling and tenderness.

• Check the groin for swollen glands and for hernia (rupture).

Rectum and Anus

• Look for hemorrhoids, which are usually swollen, blue, and often painful.

• Note if there is any blood around the anus.

Arms and Legs

• Check for movement and strength of all parts. Is there any weakness or paralysis? (If the patient is unable to move his leg, for example, find out if it is due to pain; or if it truly is paralysis, which usually causes no pain.) Is the grip stronger with one hand than the other?

• Check for swelling and for tenderness. Is it one leg or arm, or both?

Back

• Is there tenderness or deformity?
• The kidney area should be tapped gently with the fist to check for tenderness. This area lies in the back on either side of the spine and between the top of the pelvic bone and last rib.

Nervous System

• Does he show abnormal concern about his illness?

• Note general mental status. Is he rational? Is his behavior abnormal? Can he remember today's date and do simple arithmetic?

• Are his coordination and gait normal? As a test, have the patient take a few steps and pick up with each hand an object from a table or chair. If the patient is too ill to walk, note how he moves, turns over, and picks up objects in bed.

SYMPTOMS AND SIGNS

The preceding section of this chapter described how to obtain useful information on a patient. The approach included questions about symptoms, things that the patient feels and describes, plus an examination of the patient for signs or things that can be seen without relying on the patient's cooperation. The examiner's observation of the patient should begin at the head and proceed systematically to the feet.

After the examiner has obtained all the information, it must be sorted and rearranged in different ways in order for it to make sense. Related things must be brought together. A recommended way to organize the information when asking for medical advice by radio is described in Chapter XII. (See the outline, p. XII–4+.)

In general, information should be organized as it relates to body systems. From the signs and symptoms gathered, try to decide what body system(s) might be involved. Do the signs and symptoms suggest involvement of the digestive system, the excretory system, the circulatory system, or others? If possible, relate the signs and symptoms to one system. For example, pallor of the hands or feet is related to circulation—not to muscles or skeleton. So with pallor present, concern should be given primarily to blood pressure, heart rate, signs of bleeding, or evidence of injury to an artery, instead of signs of arthritis or skin rashes.

MAKING CONCLUSIONS

One way to approach the problem of diagnosis is to write down the main complaints, note the body systems that might be involved, and ask more detailed questions about these symptoms. The physical examination may be performed, again noting the body systems affected by the abnormal findings. If necessary, ask further questions or reexamine areas that will help to clarify the findings. Often by a process of elimination, the problem will be reduced to a few possible diagnoses. Next, turn to the chapters of this book that describe the diseases or conditions possibly involved, and decide which one comes closest to explaining all the signs and symptoms. The material in the chapters might suggest other special tests or additional questions that should be asked.

At this point, if a definitive diagnosis cannot be made, knowledge of the case will be sufficient for presentation by radio to a physician. Also, it will be easier to follow the course of the disease as it progresses. Some parts of the physical examination will have to be repeated daily. Changes that are observed in the patient should be recorded.

Body discharges, such as vomitus, feces, sputum, and urine should be examined carefully to note abnormal color, consistency, and above all the presence of blood. Blood in the feces may be bright red, dark brown, or have the color of tar. Blood in the urine is usually red in color; but the urine may have to settle for several hours before blood can be seen. If the patient appears jaundiced, his urine usually

will have a dark yellow color. To confirm a jaundiced condition, the urine should be put into a small bottle and shaked vigorously. In jaundice the foam will have a yellow color; normally the color of the foam is white. This can be compared to a normal urine specimen. The volume of vomitus, diarrhea, and urine output should be measured and recorded.

Two important final points: *First,* when in doubt always compare the physical findings on a patient to those of a normal person; or compare corresponding left and right parts, as the eyes or ears in the same patient. *Second,* continue to observe and recheck the patient for things that may have been missed. Avoid a quick decision or diagnosis! Snap decisions might be wrong and the illness could be prolonged.

DIAGNOSING THE UNCONSCIOUS PATIENT

Signs and symptoms of several causes of unconsciousness are shown in Table 2–2. Although the specific cause of the unconsciousness may not be known at once, an orderly diagnostic routine is urgent. Immediate findings may call for first aid measures. Some general rules follow:

1. Breathing and bleeding are top priorities. First, make sure that the airway is open; if there is no breathing, begin artificial respiration at once. Make a quick overall check for serious bleeding; if found, it must be stopped.

2. Unless the patient is lying in a dangerous spot, do not move him until first aid is completed.

3. Remove spectacles or dentures and loosen tight clothing around neck, chest, and abdomen.

4. Look into the patient's wallet for a *card,* or elsewhere on his person for a *metal tag or bracelet* that shows the *Emergency Medical Identification Symbol.* The symbol identifies people with special medical problems that might be neglected in an emergency or aggravated by usual emergency treatment. (See p. II–11 for additional information.)

5. If the patient is breathing, lay him on one side so vomitus will run out of the mouth and the tongue will be kept from falling back into the throat to choke him.

6. If breathing seems difficult, extend the head by pushing the jaw forward with fingers pressing behind the angle of the jaw. This will keep the tongue from falling back into the throat.

7. Put blankets or coats over and under the patient to keep him warm.

8. Give nothing by mouth until the patient regains consciousness.

9. Never give morphine sulfate; an unconscious patient does not feel pain.

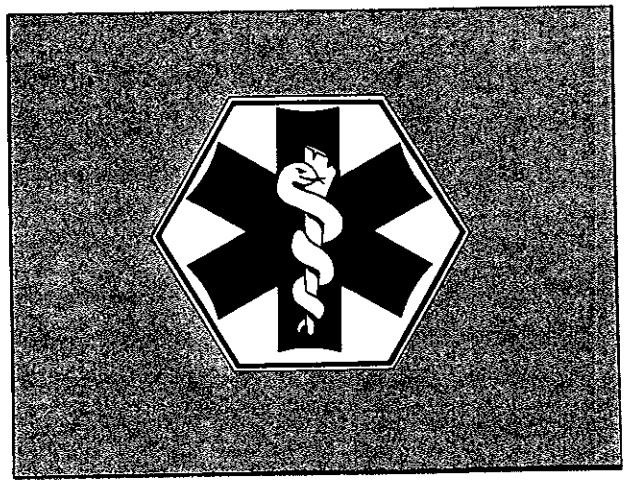
10. Keep him under continuous observation, noting color of face and rates of pulse and respiration. If the face is pale, the head should be on the deck. If the face is flushed, use a pillow, rolled clothing, or towels underneath head and shoulder to raise these a few inches.

11. If the patient is restless, restrain gently any movements that might be injurious—but do not use force.

12. As consciousness returns, treat for shock (see p. III–9).

13. Question observers of the incident that caused the unconsciousness before taking a history or making a more detailed examination.

14. Get medical advice by radio. When a specific diagnosis is made, refer elsewhere in the text for further treatment. (Also refer to Chapter III for more detail on the emergency treatment of injuries.)



Emergency Medical Identification Symbol.

Table 2-2. **DIAGNOSING**

	1 Fainting	2 Concussion	3 Brain compression	4 Epilepsy	5 Apoplexy (stroke)	6 Alcohol	7 Opium and morphine
Onset	Usually sudden	Sudden	Usually gradual	Sudden	Sudden as a rule	Gradual	Gradual
Mental condition	Complete unconsciousness	Unconsciousness but sometimes confusion only	Unconsciousness deepening	Complete unconsciousness	Complete or partial unconsciousness	Stupor, later unconsciousness	Unconsciousness deepening
Pulse	Feeble and fast	Feeble and irregular	Gradually slower	Fast	Slow and full	Full and fast, later fast and feeble	Feeble and slow
Respiration	Quick and shallow	Shallow and irregular	Slow and noisy	Noisy, later deep and slow	Slow and noisy	Deep, slow, and noisy	Slow, may be deep
Skin	Pale, cold, and clammy	Pale and cold	Hot and flushed	Livid, later pale	Hot and flushed	Flushed, later cold and clammy	Pale, cold, and clammy
Pupils	Equal and dilated	Equal	Unequal	Equal and dilated	Unequal	Dilated, later may contract. Eyes blood-shot	Equal, very contracted
Paralysis	None	None	Present (of leg or arm)	None	Present in leg, arm, or face or all three, on one side	None	None
Convulsions	None	None	Present in some cases	Present	Present in some cases	None	None
Breath	—	—	—	—	—	Smells of alcohol	With opium, musty smell
Special points	Often giddiness and swaying before collapse	Often signs of head injury. Vomiting on recovery	Often signs of head injury. Remember delayed onset of symptoms	Tongue often bitten. Urine or feces may be voided. Sometimes injury in falling	Over middle age. Eyes may look to one side. Sometimes loss of speech	Absence of the smell of alcohol excludes it as cause, but its presence does not prove that alcohol is the cause	Look for source of supply

Source: International Medical Guide For Ships. World Health Organization, Geneva, Switzerland. 1967. pp. 84-85.

THE UNCONSCIOUS PATIENT

8 Barbiturate (sedative tablets)	9 Uremic coma	10 Sunstroke and heat-stroke	11 Electric shock	12 Cyanide (prussic acid)	13 Diabetic coma	14 Shock	
Gradual	Gradual	Gradual or sudden	Sudden	Very rapid	Gradual	Gradual	**Onset**
Stupor, later deepening unconsciousness	Very drowsy, later unconsciousness	Delirium or unconsciousness	Unconsciousness	Confusion, later unconsciousness	Drowsiness, later unconsciousness	Listlessness, later unconsciousness	**Mental condition**
Feeble and fast	Full	Fast and feeble	Fast and feeble	Fast and feeble, later stops	Fast and feeble	Fast and very feeble	**Pulse**
Slow, noisy, and irregular	Noisy and difficult	Difficult	Shallow and may cease	Slow, gasping, and spasmodic	Deep and sighing	Rapid and shallow with occasional deep sigh	**Respiration**
Cold and clammy	Shallow, cold, and dry	Very hot and dry	Pale, may be burnt	Cold	Livid, later pale	Pale, cold, and clammy	**Skin**
Equal, somewhat contracted	Equal and contracted	Equal	Eyes may squint	Equal, staring eyes	Equal	Equal, dilated	**Pupils**
None	None	None	May be present	None	None	None	**Paralysis**
None	Present in some cases	Present in some cases	Present in some cases	Present	None	None	**Convulsions**
—	Sometimes smells of urine	—	—	Smells of bitter almonds	Smells of acetone	—	**Breath**
Look for source of supply	Vomiting in some cases	Vomiting in some cases	Muscular spasm often causes tight gripping of the electrified object	Rapid deterioration. Breathing may stop	In early stages, headache restlessness, and nausea. Test urine for sugar	May vomit. In early stages shivering, thirst, defective vision, and ear noises	**Special points**

Why You Should Carry Emergency Medical Identification

An emergency medical identification card is your protection in an emergency. If you are not able to tell your medical story after an accident or sudden illness, the information entered on this card can save your life.

You may have health problems which can affect your recovery from an emergency. You may have a problem which is no emergency but often is treated as one, such as epilepsy. Even if you do not have a health problem, the information on this card can be of valuable assistance to the first aid attendant.

Why You Should Wear an Emergency Medical Signal Device

In an emergency, you may be separated from your pocket card. Possibly you are one who has a medical problem so critical that it must be immediately known to those who help you. If so, a signal device of durable material should be worn around your neck, wrist, or ankle in such a way that it can be present at all times—even while swimming.

The device should be fastened to the person wearing it with a strong nonelastic cord or chain so designed that it does not become an accident hazard in itself.

On this device there should be:

- The universal symbol of emergency medical identification
- The name of your major health problem
- For children and the aging, the name and address of a responsible relative and a telephone number, including area code

Carry Your Card and Wear Your Signal Device at All Times!

Detach card here

EMERGENCY MEDICAL IDENTIFICATION

ATTENTION

In an emergency where I am unconscious or unable to communicate, please read the other side to know the special care I must have.

PERSONAL IDENTIFICATION

Name_____

Address_____

_____

_____

Religion_____

NOTIFY IN EMERGENCY

Name_____

Address_____

_____

Phone_____

Name_____

Address_____

_____

Phone_____

My Doctor is_____

_____

Address_____

_____

Phone_____

MEDICAL INFORMATION

(with date of notation)

Present Medical Problems_____

Medicines Taken Regularly_____

Dangerous Allergies_____

Other Important Information_____

Last Immunization Date

Tetanus Toxoid_____ Polio: Salk_____
Diptheria_____ Sabin_____
Smallpox_____ Typhoid_____
Measles_____ Others_____

REMEMBER: This is the minimum medical and personal information needed by those who help you in an emergency. It is not designed to be a complete medical record. Check its accuracy with your doctor.

Detach card here

To put your EMERGENCY MEDICAL IDENTIFICATION CARD to work for you, fill in both sides of this card. **For example,** under

Present Medical Problems, include:

Epilepsy	Tracheotomy (neck breather)
Diabetes	Pneumothorax
Glaucoma	Pneumoperitoneum
Hemophilia	Colostomy
Chorea	

Medicines Taken Regularly

Anticoagulants	When noting drugs, ask your doctor for the name to use that will be easy to identify in an emergency.
Cortisone or ACTH	
Heart drugs such as digitalis or nitrites	
Thyroid preparation	

Dangerous Allergies

Drug allergies	Feathers (pillows)
Horse serum (as in tetanus antitoxin)	Common foods
	Penicillin sensitivity

Other Information

Scuba diver	Speak no English (note the language you speak)
Recurring unconsciousness	
Hard of hearing	Wearing contact lenses

Immunizations

The date is important. If you note immunization over three years old, ask your doctor about a booster immunization. For tetanus toxoid, note the date of your first immunization as well as your last.

Fig. 2-1. Emergency medical identification (EMI) card.

Emergency Medical Identification Symbol

Stop! Look before you treat. This is the message of the *Emergency Medical Identification (EMI) symbol* that is worn or carried by many people. The American Medical Association designed the symbol to identify people who have medical problems that might be neglected in an emergency or aggravated by usual emergency treatment.

Learn to recognize the symbol. It may save a life or lessen disability. Worn as a bracelet, necklace, or anklet, the symbol means that the person has special health needs that must not be ignored if he is injured or suddenly taken ill. A card in pocket, wallet, or purse will explain the patient's special needs. Everyone with special medical problems, or who takes medicines regularly, or has dangerous allergies, or who requires special medical attention of any kind—such as the hard-of-hearing, heart patients, contact lens wearers, epileptics, diabetics, or non-English speakers—should wear the *Emergency Medical Identification* symbol, or carry an *Emergency Medical Identification* card.

EMI Cards and Emblems

Pocket or wallet cards are available from the American Medical Association or some voluntary health agencies that deal with special health problems. (See sample card on previous page.) Bracelets and necklaces may be obtained from several sources including the Medic Alert Foundation, Turlock, California 95380.

For information about the symbol and its uses, contact the

American Medical Association
535 North Dearborn Street
Chicago, Illinois 60601.